

Committee on Ways and Means

How the House Medicare Bill Immediately Helps Rural and Suburban America

Our Medicare bill corrects existing inequities by infusing billions of dollars over the next decade into rural and small towns as well as small hospitals everywhere. The proposal will include the following provisions that benefit rural and suburban areas:

- **Labor Share.** The labor share of the usage index used for hospital reimbursement drops from 71% to 62% for low wage areas. All other areas held harmless. \$5.4 billion
- **Standardized Amount.** Immediately increases the standardized amount (or base payment rate) for rural hospitals and hospitals in cities under 1 million by 1.6%, up to the large urban payment rate. \$7.9 billion
- **Disproportionate Share (DSH).** Immediately increases DSH payments for small rural and urban hospitals by almost doubling the amount of allowed payments (5.7 to 10 % of total Medicare inpatient payments). \$2.1 billion
- **Essential Hospitals.** Creates a new category of hospitals, regardless of size, which are the healthcare lifeline for their communities. After meeting access, clinical and quality criteria, these hospitals would be paid costs plus 2%. \$0.4 billion
- **Critical Access Hospitals (CAH).** \$0.4 billion
 - Pays costs plus 2% to ensure that these hospitals can improve access and services;
 - Reinstates special cash flow provision (Periodic Interim Payments) and asks the Secretary to tailor these payments to small hospitals;
 - Fixes special physician payment adjustment so that local physicians and visiting specialists receive a 15% bonus for hospital outpatient services;
 - Creates flexibility in the bed size requirement for current and future CAHs;
 - Extends coverage of costs to retain emergency on-call providers to physician assistants, nurse practitioners and clinical nurse specialists;
 - Allows for cost-based CAH-ambulance services if the only ambulance is within 35 miles or is the first responder to emergency services; and,
 - Reauthorizes rural flexibility grants.
- **Wage Index.** Reforms wage index reclassification by allowing another option based on commuting rather than arbitrary distance criteria. \$0.3 billion
- **Graduate Medical Education (GME).** Allows hospitals in rural areas and small cities that provide graduate medical education to receive additional direct medical education and indirect teaching hospital funds by moving unused residency slots to these hospitals. \$1.5 billion
- **Sole Community Hospitals.** Allows hospitals to qualify as sole community hospitals that are missing some of the qualifying data. \$0.1 billion
- **Hospital Outpatient.** Extends by two-years outpatient financial protections from new payment system for small rural hospitals and sole communities. \$0.3 billion
- **Hospital Outpatient.** Targets additional funds at high cost drugs. \$1.0 billion
- **Physicians.** Adds a 5 percent bonus payment for primary care and specialty care physicians providing care in physician scarcity areas. \$6.0 billion

- **Physician Geographic Adjustor.** Establishes a floor on the work component of the physician geographic adjustor; raises payments in low cost of living areas. \$0.4 billion
- **Clinics.** Pays separately for the professional services of rural health care clinics and federally qualified health centers to treat skilled nursing patients. \$0.1 billion
- **Low Volume Rural Ambulance.** Targets higher payments for ambulances in counties with a lower Medicare population. \$0.4 billion
- **Home Health.** Adds a 5 % increase for all rural home health agencies for two years. \$0.2 billion
- **Nurse Practitioners.** Allows nurse practitioners to continue acting as independent practitioners for hospice patients. \$0.1 billion
- **Community Health Centers.** Provides safe harbor for community health center activities around donations and other remunerations to be used in providing services to medically underserved areas.
- **Practitioners.** Allows practitioners employed by rural health clinics and community health centers to bill separately for services provided to skilled nursing residents. \$0.1 billion
- **Independent Pathology.** Grandfathers existing relationships that are common for rural hospitals for separate payment and billing for pathology. \$0.6 billion